LIFEPOINT CHILD & FAMILY THERAPY

CLIENT REGISTRATION SHEET

Today's Date:		

CLIENT INFORMATION

Last Name: First: Middle:	Marital status: (circle one) Single / Married Div / Sep / Wid Partnership	Identify as: ❑ Heterosexual ❑ Gay ❑ Lesbian ❑ Queer ❑ Transgender ❑ _____	Preferred Pronoun: ❑ She ❑ He ❑ They/them ❑ _____

Street Address:	City:	State:	ZIP Code:

Home phone no.: OK to contact? Y N ( )	Cell phone no.: OK to text? Y N ( )	Social Security no.:	Birth Date: / /	Sex at birth: ❑M ❑ F

Employer:	Occupation:	Work phone no.: ( )

Street Address:	City:	State:	ZIP Code:

Current Email: ok to contact? ❑ Y ❑ N	@ ❑ gmail ❑other: @ ❑yahoo
Referring Source:	

Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact no.: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):** First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status of insured (circle one): Single / Mar / Div / Sep / Wid / Partnership

Home phone no.: **(if different)** ( )	Cell/Other contact no.: ( )	Social Security no.:	Birth Date: / /	Sex at birth: ❑M ❑ F

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )

Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse ❑ Dependent	CoPay Amount:

IF CLIENT IS A MINOR:

Parent 1 Name:	Parent 2 Name:	With whom child resides:

Custody agreement (if applicable):	Step Parents (if applicable):	Child's School:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize LifePoint Therapy, those acting on the practice's behalf, and my insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

_____ _____

Patient/Guardian signature *Date*

*** PLEASE NOTE: 48 HOUR CANCELLATION POLICY – Please be advised that 48 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount.**
Thank you for your cooperation.

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone: ( )	Cell phone: ( )

CURRENT PRESENTING PROBLEMS FOR CLIENT

(Check any that may apply)

❑ depression ❑ anxiety ❑ family issues ❑ sexuality/sexual identity ❑ substance use ❑ mood instability ❑ adjustment to college life ❑ academic problems ❑ disordered eating/body image ❑ bullied ❑ feeling overwhelmed ❑ child behavior management ❑ trouble sleeping ❑ obsessive thoughts/behaviors ❑ feeling numb ❑ family member uses substances	❑ learning disability ❑ ADHD diagnosed ❑ sexual assault ❑ inability to focus ❑ truancy ❑ grief ❑ psychoses/delusions ❑ unwanted thoughts ❑ overly aware of environment ❑ aggression ❑ acts mean towards others ❑ feeling alone ❑ low self esteem ❑ panic attacks ❑ nightmares ❑ other:	Other/Details:

MEDICATIONS

Past Psychotropic Medication:

Medication	Dates On/Off	Prescribing Physician	Reason For Taking:
Medication	Dates On/Off	Prescribing Physician	Reason For Taking:

Current Psychotropic Medication:

Medication	Dates On/Off	Prescribing Physician	Reason For Taking:
Medication	Dates On/Off	Prescribing Physician	Reason For Taking:

PAST TREATMENT

❑ Y ❑ N Previous psychotherapy	❑ Y ❑ N Psychiatric Hospitalizations	❑ Y ❑ N Suicide Attempts ❑ Y ❑ N Suicidal Thoughts ❑ Y ❑ N Homicidal Thoughts
Dates/Reason:	Dates/Reason:	Date(s):

OTHER QUESTIONS

What are your strengths?
What do you do for fun?
What are you hoping to gain from therapy?